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No. 1378

In the

# Supreme Court of the United States

OCTOBER TERM, 1970

GROUP LIFE & HEALTH INSURANCE COMPANY,
*Petitioner,*

*v.*

UNITED STATES OF AMERICA,
*Respondent.*

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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UNITED STATES OF AMERICA,
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## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Group Life & Health Insurance Company (hereinafter called Petitioner) petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

## OPINIONS BELOW

The decision of the District Court (App. A, *infra*)[1] is not officially reported. It is unofficially reported at 69-2 USTC Par. 9692 and 24 AFTR 2d 5778. The opinion of the Court of Appeals (App. B, *infra*) is reported in 434 F. 2d 115.

[1] "App." refers to the appendix to this petition. "R." references are to the printed record in the Court of Appeals.

## JURISDICTION

The judgment of the Court of Appeals was entered on November 5, 1970, (App. B, *infra*). By order dated November 18, 1970, the time period for filing the Petition for Rehearing was extended to November 30, 1970. Petition for Rehearing and for Rehearing En Banc was filed on November 27, 1970, and was denied on January 8, 1971, (App. C, *infra*). The jurisdiction of this Court is invoked under 28 U.S.C., Section 1254(1).

## STATUTE AND REGULATIONS INVOLVED

The relevant provisions of the Federal Rules of Civil Procedure are set forth in App. D, *infra*. The relevant provisions of the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959, are set forth in App. E., *infra*, and the relevant Treasury Regulations, Sections 1.801-1, 1.801-3 and 1.801-4, thereto are set forth in App. E, *infra*.

## QUESTIONS PRESENTED

1. Whether the Court of Appeals erred in deciding *de novo* an essential disputed issue of fact not decided by the District Court without remanding the case to the District Court for determination of the disputed issue of fact in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

2. (a) Whether the Court of Appeals erred in holding that the Commissioner of Internal Revenue could demand

the establishment of certain insurance reserves in determining whether Petitioner was a life insurance company under Section 801(a) of the Internal Revenue Code of 1954 when those reserves were not required by state law.

(b) Whether the Court of Appeals erred in holding that Treasury Regulations, Section 1.801-3(d) was a reasonable and valid interpretation of Section 801(e) in defining a guaranteed renewable contract.

## STATEMENT

Petitioner is organized and operated as a life insurance company under the insurance laws of the State of Texas and is commonly known as Blue Shield. It is authorized to, and does, issue *only* life insurance and health and accident insurance policies. The question involved is whether Petitioner is taxable as a life insurance company under Section 801(a).[2] This question turns on the determination of whether Petitioner's group medical-surgical policy is a guaranteed renewable health and accident contract within the meaning of Section 801(e).

The Treasury Regulations, Section 1.801-3(d) (App. F, *infra*) to Section 801(e) set forth three requirements to qualify; namely, (1) the policy cannot be cancelled by the company; (2) the company must reserve the right to adjust premium rates by classes in accordance with its experience under the type of policy involved, and (3) a reserve in addi-

[2] All section references are to the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959, unless otherwise identified.

tion to the reserve for unearned premiums and unpaid losses must be developed by the policy.

In the District Court the parties stipulated that Petitioner's policy met the first two requirements; namely, it was "a health and accident contract which cannot be cancelled by the Company but under which the Company reserves the right to adjust premium rates by classes in accordance with its experience under the type of policy involved." (R. 80). It was stipulated that the disputed question of law was (R. 78):

> In order to constitute a guaranteed renewable health and accident insurance contract under Section 801, is it necessary that the policy require a reserve in addition to the unearned premium and unpaid loss reserves?

and that in the event the Court answered the question of law in the affirmative, the only disputed question of fact was (R. 79):

> Whether the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" issued by Plaintiff develops a reserve in the nature of a life insurance reserve in addition to reserves for unearned premiums and reserves for unpaid losses.

The District Court held, as a matter of law, no additional reserve was required and did *not* decide the essential disputed fact question of whether Petitioner's policy developed the additional reserve.[3]

[3] The parties had stipulated that "In the event the Court answers the question of law in the negative, [that no additional reserve is required] then the parties agree there exists no undisputed question of fact." (R. 79)

The Court of Appeals for the Fifth Circuit disagreed with the District Court on the only disputed question of law, holding that the policy must develop the additional reserve to be a guaranteed renewable contract. The Court of Appeals acknowledged that the essential disputed fact of whether the policy in issue developed the additional reserve was not decided by the District Court below. (App. B, *infra*, pp. 9, 10) The Court of Appeals, without remanding the case for a determination of the essential fact question by the District Court, made the factual determination on its own.

The Court of Appeals, in its opinion, stated (App. B, *infra*, p. 9):

> The question remains whether Group Life's policy in fact *developed the additional reserves* required by Section 1.801-3(d) of the Regulations. Although the parties stipulated in the District Court this question to be the sole disputed fact, *that Court made no finding of fact within Fed. R. Civ. P. 52(a)* regarding it. Because Judge Estes concluded as a matter of law that no additional reserves are needed by Group Life to qualify as a life insurance company, *he did not have to resolve the foregoing question of fact.* (Emphasis added)

The Court of Appeals then attempted to resolve the only essential disputed issue of fact *de novo* in three sentences. It stated that no such reserve was reported in Petitioner's annual financial statements and that Petitioner's witnesses had not established the existence of or the need for such a reserve and that the Government's actuary had testified that the policy involved would not develop such a reserve. It dismissed the testimony of the only witness in the case who had knowledge of the initial premium structure of

the policy involved on the ground that her testimony involved only the computation of the initial premium and not the use to which the funds were put. The Court's opinion concentrates on the fact that the reserve was not set up on Petitioner's books and not on the issue, as stipulated by the parties, of whether the policy *developed* the reserve.

There is no dispute between Petitioner and the Government that if an additional reserve was required the *only* method of determining whether the policy developed the reserve was to analyze the initial premium and compare it to the frequency curve of the benefits provided. The Government, in its brief in the Court below, recognized this when it stated: "A company's requirement for reserves depends on the benefit and premium provisions of the policies it issues." (Brief for Appellant, p. 16, fn. 9) The Government's actuary testified that in order to determine whether a reserve is developed under the policy involved requires an examination of the structure of the initial premium and to compare the premium to the benefits provided under the contract. (R. 225-226) Petitioner agrees with the Government that this is the only method to determine whether Petitioner's policy developed the additional reserve.

Both the Petitioner and the Government introduced evidence on this point. Petitioner's statistician, the only witness who had examined the initial premium structure of the policies involved, testified that the initial premium did in fact contain a reserve element. One of Petitioner's officers testified that although it was determined that such a reserve could be calculated (from the initial premium),

Petitioner decided not to do so because the reserve was not required by the Insurance Department of the State of Texas, it would be very expensive to compute and the amount of the additional reserve would be small, if any at all. (R. 168) The Government's only witness, the actuary, agreed that the only way to determine whether the policy involved developed the reserve was to examine the initial premium to see if it contained an element from which the reserve could be set aside. However, he admitted on cross-examination that he *had not* examined the structure of the initial premium for the policy involved in this case. (R. 227) Nevertheless, he testified in his opinion the policy involved did not develop the additional reserve. *The basis of his opinion was his assumption that the initial premium did not contain any element from which the reserve could be set aside.* He came to this conclusion even though he *had not* examined the initial premium of the policy involved and even though Petitioner's statistician testified that an element for the reserve was included in the initial premium. Thus, despite a clear conflict in the testimony, the Court of Appeals accepted the unsupported testimony of the actuary without understanding the vital importance of the composition of the initial premium of the policy, nor the basis for the actuary's conclusion.

## REASONS FOR GRANTING THE WRIT

1. The Court of Appeals attempted determination of an essential question of fact (not decided by the District Court) without remand to the trial court is not fair com-

pliance with Rule 52(a), Fed. R. Civ. P., conflicts with the decisions of this Court and with the decisions of other Courts of Appeal. This case clearly comes within Rule 19(1) (b) of this Court because of the conflicts and because the Court of Appeals below has so far departed from the accepted and usual course of judicial proceedings as to call for an exercise of this Court's power of supervision.

Not only was there a substantial departure from Rule 52(a) and the decisions of this Court and of other Circuit Courts of Appeal, but *a substantial departure from well-accepted trial court norms and standards.* Here, the Court of Appeals made mistakes even the most inexperienced trial judge would not have made. The Court of Appeals did not understand the essential question of fact and the only manner in which it could be resolved. Without having heard the witnesses testify, it resolved conflicting testimony. It rested its decision on the testimony of an actuary who admitted on cross-examination that he had not examined the premium structure and level of benefits of the policy involved, which the parties agreed (as did he) was the only manner that the factual question involved could be determined. All of these are, in the first instance, the proper concern of the trial judge — the determination of the fact issue — the weighing of evidence — especially oral testimony, to determine an essential fact. Here, a substantial and complex fact issue was attempted to be resolved by the Fifth Circuit in a three sentence *trial de novo.* When appellate courts attempt to become triers of fact, they easily fall into error. The instant case is a perfect example.

In the judicial proceeding, Rule 52(a) requires that district courts "shall find the facts" and that "Findings of fact shall not be set aside unless clearly erroneous * * *" and that "* * * due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses." Rule 52(a) is mandatory and places the fact finding burden squarely on the trial court who is in the best position to judge the credibility of the witnesses and resolve conflicts in evidence. The entire responsibility for deciding doubtful fact questions in a non-jury case should be and is that of the district court and review courts of appeal should refrain from exercising any of the trial functions conferred by law on district courts. (*Pendergrass v. New York Life Insurance Co.*, 181 F. 2d 136 (C.A. 8, 1950)) The importance of the trial court's findings is further demonstrated by Rule 63, Fed. R. Civ. P., which requires a retrial upon the death or disability of the trial judge prior to the filing of findings of fact.

The decision of the Fifth Circuit resolving the disputed fact issue and not remanding to the District Court is in conflict with the decision of this Court in *Kelley v. Everglades Drainage Dist.*, 319 U.S. 415 (1943) and thereby provides the basis for the granting of the Writ of Certiorari in this case. The *Kelley* case is almost identical to the present one and coincidentally came to this Court on Certiorari from the Fifth Circuit. There, this Court was asked to review a plan for the composition of debts. The petitioners contended in this Court and in the courts below that the plan was discriminatory and that the record

lacked the findings of fact required by statute and the General Orders in Bankruptcy. The Fifth Circuit had approved the plan.

This Court held that in the absence of suitable findings the petition for writ of certiorari should be granted, the judgment of the Fifth Circuit vacated and the cause remanded to the district court with instructions to make the required findings of fact. In so holding, this Court stated:

> * * * It may be that adequate evidence as to these matters is in the present record. On that we do not pass, for it is not the function of this court to search the record and analyze the evidence in order to supply findings which the trial court failed to make. * * * We hold only that *there must be findings*, stated either in the court's opinion or separately, which are sufficient to indicate the factual basis for the ultimate conclusion. * * * (Emphasis added)

This Court has consistently required a case to be remanded to the trial court or fact finding commission when that court has failed to find essential facts. With respect to this Court's issuing rules almost identical to Rule 52(a) governing appeals in equity and admiralty cases, Justice Felix Frankfurter and James M. Landis in "The Business of the Supreme Court at October Term, 1929", 44 Harvard Law Rev. 1, at p. 26, stated:

> The Court's admonitions remained unheeded, and at the last term it must have concluded that for the presentation of proper records it could no longer rely upon the self-discipline of bar and bench. Evidently *Railroad Comm. v. Maxcy* and *Panama Mail S.S. Co. v. Vargas* were the immediate occasions of the promulgation of

> new rules governing Supreme Court reviewof equity and admiralty appeals. In both classes of casesafter October 1, 1930, the "court of first instance shallind the facts especially and state separately its concsions of law thereon * * *" On the surface these res appear as innovations. In fact, they constitute theestoration of early Supreme Court practice. * * * (Foootes omitted, emphasis in original)

The authors point out in a footnote (32) tt in *Panama Mail S.S. Co. v. Vargas*, 281 U.S. 670 (1930) counsel, both orally and in their briefs, made the main rden of their argument the failure of the district court tmake findings or to write an opinion. It was this ground un which certiorari was sought and granted.

In *Panama Mail, supra*, an admiralty su the district court delivered no opinion and made no flings of fact other than might have been implied from t decree. The Court of Appeals affirmed the lower court the ground that appellate courts refuse to review decisior ial courts based on conflicting testimony unless there s of trial courts is an error of fact or misapplication of law. After noting hat this was a case where the evidence was in conflict and in which there had been no distinct finding of facts by the court primarily charged with their determination, this Cou t stated:

> In the present case we think the sit uation requires that the decrees in both courts below be vacated and the case remanded to the District Co urt, with a direction to make specific findings of fa t and to take such further proceedings as may be in conformity with law.

> If the judge who presided at the trial and rendered the decree is prepared to make such findings without a further trial, that course may be taken; otherwise the case should be retried.

In *Railroad Commission of Wisconsin, et al v. Maxcy*, 281 U.S. 82, (1930), where there were no findings whatever, this Court required the case to be remanded to the three judge district court to state its findings of fact and conclusions of law, citing numerous cases of this Court which have repeatedly adverted to the importance of fact finding by the district court as an indispensable aid to this Court on appellate review.

This Court has repeatedly and continuously required a remand to the trial court where there has been a failure to find essential facts and has not taken upon itself the role of the fact finder as did the Court of Appeals in the instant case. See *Borden's Farm Products Co. v. Baldwin*, 293 U.S. 194 (1934); *United States v. Esnault-Pelterie*, 299 U.S. 201 (1936); *Interstate Circuit v. United States*, 304 U.S. 55 (1938), (in which this Court held that compliance with old Equity Rule 70½ required the district court to make formal findings and that this was an essential aid to the appellate court); *Mayo v. Lakeland Highlands Canning Co.*, 309 U.S. 310 (1940), (case was remanded to trial court by this Court with instruction that any action taken by the Court shall be upon findings of fact and conclusions founded upon the evidence, in accordance with Rule 52(a) of the Federal Rules of Civil Procedure and *that fair compliance with Rule 52(a) was mandatory*).

This Court is thus firmly on record that there "must be findings" and this is to be done by the district court, not by the Court of Appeals. Certainly, if this Court cannot adequately review a case without such findings, it is difficult to understand how a Court of Appeals can do so (as was done in this case).

In *Whipple v. Commissioner*, 373 U.S. 193 (1963), this Court remanded the case to the trial court (Tax Court) to determine whether Whipple's loan was proximately related to his business of being a landlord which had not been decided by the trial court. This Court did not (as did the Court of Appeals in this case) take it upon itself to resolve conflicting evidence and play the role of the trial court. The case was properly remanded to the trial court and not the appellate court.

It is not the function of the appellate court to assume the powers of the trial court which it does necessarily when, as here, it tried *de novo* the essential fact question which admittedly had not been decided by the District Court. (See *Schilling v. Schwitzer-Cummins Co.*, 142 F. 2d 82, (C.A. DC, 1944)). The circuit courts of appeal have appellate jurisdiction to review by appeal. Rule 52(a) expressly gives the fact finding function to the district court. Without the required finding of an essential question of fact, it is impossible for an appellate court to apply the "unless clearly erroneous" test which assumes that a finding of fact has been made by the district court. (See *United States v. United States Gypsum Co.*, 333 U.S. 364, reh. den. 333 U.S. 869 (1948)).

In *McClure v. O'Henry Tent & Awning Co.*, 184 F. 2d 636, 639 (C.A. 7, 1940), the Seventh Circuit announced the correct rule to be applied to this case when it stated:

> Having found that the delivery dates were indefinitely extended, the court should have proceeded to find as a fact whether such indefinite extension had been duly terminated, and, if so, when. Rule 52(a) requires that in all cases tried without a jury, the court shall find the facts specially. Of course a court of appeals need not reverse a judgment because of failure to comply literally with this rule if the findings are sufficiently comprehensive and pertinent to the issues to provide a basis for the decision. *However, where, as here, because of an error in law the court failed to make any finding as to a fact vital to the decision of the cause, the evidence as to which is in dispute, we must remand the cause for the purpose of enabling the trial court to make the necessary finding.* Campbell v. Campbell, 83 U.S. App. D.C. 237, 170 F. 2d 809; Indemnity Ins. Co. v. Midwest Transfer Co., 7 Cir., 184 F. 2d 633. (Emphasis added)

This is precisely what happened in the instant case. Because of an error of law, the District Court failed to determine an essential question of fact; namely, whether the policy involved developed the requisite reserve — about which the evidence was in dispute and the Fifth Circuit should have remanded the cause for the purpose of enabling the trial court to make the necessary finding.

As shown above, this Court itself has consistently avoided the error committed by the Fifth Circuit in this case by requiring cases to be remanded to the trial court when that court has failed to make an essential finding of fact in cases before it.

The Ninth Circuit has unequivocally stated in *Lundgren v. Freeman*, 307 F. 2d 104 (C.A. 9, 1962), at p. 114:

> Nothing in the history of review of equity cases or of law cases tried without a jury suggests that the appellate court *ever* decides issues of fact in the first instance, even where it considers itself as fully qualified as the trial judge to do so. * * * (Emphasis added)

The Fifth Circuit's decision in this case clearly conflicts with the Seventh Circuit's decision in the *McClure* case, *supra*, and the Ninth Circuit's decision in *Lundgren*, *supra*, and this Court should grant this petition to resolve such conflict. The Fifth Circuit's opinion in this case also conflicts with *Saginaw Broadcasting Co. v. Federal C. Com'n*, 96 F. 2d 554 (C.A. DC, 1938); *Campbell v. Campbell*, 170 F. 2d 809, 810 (C.A. DC, 1948), "*It is not our duty to make findings, and we could not soundly do so — not having heard the witnesses.*"; *Jones v. Waterman S.S. Corporation*, 155 F. 2d 992 (C.A. 3, 1946) and *Bowles v. Russell Packing Co.*, 140 F. 2d 354, 355 (C.A. 7, 1944), "*A fair compliance with this rule is mandatory.* Mayo, Commissioner v. Lakeland Highlands Canning Co., 309 U.S. 319, 316, 60 S. Ct. 517, 84 L. Ed. 774." (Emphasis added)

This Court should enter an order here, as it did in *Kelley v. Everglades Drainage Dist.*, *supra*, stating that "* * * the petition for writ of certiorari is granted, the judgment is vacated, and the cause remanded to the District Court * * *" for the purpose of making findings of fact on the only stipulated disputed question of fact.

2. (a) The decision of the Fifth Circuit in this case on the legal issue is in conflict with the decision of this Court in *Helvering v. Oregon Mutual Life Insurance Co.*, 311 U.S. 267 (1940). The Fifth Circuit held, contrary to this decision, that the Commissioner of Internal Revenue could demand by regulation that certain reserves be established for a health and accident policy to be guaranteed renewable contract under Section 801(a), notwithstanding the fact that state law (Texas) did not require the establishment of such reserves.

The Fifth Circuit's decision is an incorrect interpretation and erroneous application of the provisions of subsections (a), (b) and (c) of Section 801. Subsection (a) defines a life insurance company and subsection (b) defines a life insurance reserve. Subsection (c) provides the definition of total reserves. Life insurance reserves under subsection (b) must be required by state law. Total reserves only include (1) life insurance reserves, (2) reserves for unearned premiums and unpaid losses, not included in life insurance reserves, and (3) all other insurance reserves required by law.

Petitioner is taxable as a life insurance company if (1) its life insurance reserves and (2) its unearned premiums and unpaid losses on non-cancellable or guaranteed renewable life, health or accident policies, not included in life insurance reserves, are more than 50% of its total reserves. The statutory provisions of Section 801, considered in light of the decisions of this Court, leave little doubt that only

reserves required by state law are to be considered in determining an insurance company's total reserves and in determining whether more than 50% of those reserves are reserves listed in Section 801(a). The Fifth Circuit's decision that the Commissioner by regulation could demand reserves not required by state law is in conflict with the statutory pattern of defining a life insurance company, which pattern was developed by decisions of this Court under the "reserve funds required by law" concept.[4]

From the Revenue Act of 1921 to the Revenue Act of 1942, the statutory language defining a life insurance company was in terms of "the reserve funds of which held for the fulfillment of such contracts [life insurance and annuity contracts] comprise more than 50 per centum of its total reserve funds." All deductions were based on "reserve funds required by law" and this Court in *Helvering v. Oregon Mutual Life Insurance Co., supra*, held that the requirement that reserves be required by law equally applied for definitional purposes. This judicial interpretation of the provisions for definition was carried forward in the Revenue Act of 1942 and was re-adopted in the Life Insurance Company Income Tax Act of 1959. Congress, by statute, has decreed that all reserves considered in the test of a life

[4] See *McCoach v. Insurance Co. of North America*, 244 U.S. 585 (1917); *Maryland Casualty Co. v. United States*, 251 U.S. 342 (1920); *New York Life Insurance Co. v. Edwards*, 271 U.S. 109 (1926); *United States v. Boston Insurance Co.*, 269 U.S. 197 (1925); *Helvering v. Inter-Mountain Life Insurance Co.*, 294 U.S. 686 (1935).

insurance company must be required by state law. Neither the Commissioner, nor the Court of Appeals for the Fifth Circuit, has authority to alter Congressional decree, for that which Congress has granted, only Congress can take away. *Helvering v. Oregon Mutual Life Insurance Co., supra.*

(b) The Court of Appeals erred in holding that Treasury Regulations, Section 1.801-3(d) was a reasonable and valid interpretation of Section 801(e) in defining a guaranteed renewable contract. Both the report of the House Committee on Ways and Means and the report of the Senate Finance Committee contained a statement as to the type of insurance contract Congress had in mind when it enacted the guaranteed renewable contract provisions of Section 801(e). Both Reports, (1959-2 Cum. Bull. 736 and 1959-2 Cum. Bull. 770, 793), state: "The type of insurance contracts referred to are life, health, and accident policies which are not cancellable by the company but under which the insurance company reserves the right to adjust premium rates by classes, in accordance with experience under the type of policy involved." Neither the Reports *nor the statute* contain any language whatsoever that to qualify there must be a reserve in addition to the unearned premium reserve, as stated in the Regulation. Thus, the Regulation is an unwarranted extension of the statutory definition of a guaranteed renewable contract and constituted a clear addition to the statute, as was held by the District Court.

## CONCLUSION

The petition for Writ of Certiorari should be granted.

Respectfully submitted,

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## CERTIFICATE OF SERVICE

It is hereby certified that service of this petition for writ of certiorari has been made on opposing counsel by mailing three copies thereof on this 19th day of February, 1971, in an envelope, with postage prepaid, properly addressed as follows:

SOLICITOR GENERAL
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# APPENDIX A

## Decision of United States District Court, Northern District of Texas, Dallas Division, No. CA 3-2095

October 8, 1969
69-2 USTC, Par. 9692
and
24 AFTR 2d 5778

GROUP LIFE & HEALTH INSURANCE COMPANY,
*Plaintiff,*

v.

U. S.,
*Defendant.*

ESTES, District Judge:

Findings of Fact and Conclusions of Law

The above-entitled cause having been tried before the Court, sitting without a jury, and the Court having fully considered the record, the Court hereby makes its findings of fact and conclusions of law pursuant to Rule 52(a) of the Federal Rules of Civil Procedure:

Findings of Fact

1. The facts admitted by the pleadings and contained in the stipulations filed in this cause are hereby adopted as facts in these findings.

2. This is an action for recovery of Federal income taxes and interest paid by Plaintiff (hereinafter referred to as Taxpayer), for the calendar years 1961, 1962, 1963 and 1964.

3. Taxpayer was incorporated under the laws of the State of Texas in 1953 as a limited capital stock company under the name of American Savings Life Insurance Company, authorized to write life, health and accident insurance. In 1960, the corporate name was changed to Group Life & Health Insurance Company.

4. Taxpayer is affiliated with Group Hospital Service, Inc. (hereinafter referred to as Group Hospital), and Group Medical & Surgical Service (hereinafter referred to as GMSS), and they are the Blue Cross and Blue Shield Plans operating in Texas.

5. Group Hospital was organized in 1939 as a Texas non-profit corporation for the purpose of establishing, maintaining and operating a non-profit hospital service plan to cover the cost of hospital care furnished to members. Group Hospital, since 1939, has been the carrier of the hospitalization insurance sold under the Blue Cross plan in Texas.

6. GMSS was organized in 1905 as a mutual assessment, life, health and accident insurance company. For the years 1945 through 1960, it was the carrier of the medical and surgical health insurance written under the Blue Shield plan in Texas.

7. The Commissioner of Internal Revenue has determined that Group Hospital and GMSS are exempt from Federal income taxes under Section 501(c) (4) of the Internal Revenue Code of 1954.

8. The Blue Cross and Blue Shield health insurance plans are underwritten and sold as a basic plan and as major medical and catastrophic illness plans. Under the basic plan, insurance coverage is provided for certain stated benefits. The major medical and catastrophic illness plans provide for coverage of a percentage of all hospitalization, medical and surgical expenses in excess of the amounts allowed under the basic plan.

9. On October 4, 1960, Group Hospital acquired all the outstanding stock of Taxpayer. In 1961, Taxpayer started underwriting the basic plan for the medical and surgical portion of the insurance (Blue Shield), which previously had been written by GMSS. Group Hospital issued the major medical and catastrophic illness coverage as supplements to the Blue Cross hospitalization contract. Group Hospital then reinsured with Taxpayer that portion of the major medical and catastrophic illness supplements of the medical and surgical coverage.

10. For the years 1961, 1962 and 1963, all of the medical and surgical policies issued by Taxpayer were for group coverage under a contract called "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy." In 1964, Taxpayer began issuing individual policies for medical-surgical coverage.

11. Taxpayer was intended to be predominant in the life insurance business as compared to the health insurance business through group life insurance policies. However, since it was management's desire to start group experience rating for the Blue Shield coverage as soon as possible, the Blue Shield business was shifted from GMSS to Taxpayer. Management, knowing that in the early years of the operation the health insurance coverage would be more than the life insurance coverage, desired to structure the medical-surgical policies in such a manner as to permit the reserves for these policies to qualify as life insurance company reserves under the Internal Revenue Code.

12. Taxpayer's officers made a study and research of the requirements necessary to make the medical-surgical policies guaranteed renewable health and accident insurance policies, in order to qualify the company as a life insurance company for tax purposes. It was their conclusion that if Taxpayer issued a health policy which did not permit the company to cancel the policy but under which the company reserved the right to adjust premium rates based on experience by class, the reserves held for these policies would be included in the computation of determining whether Taxpayer qualified as a life insurance company for Federal income tax purposes.

13. The policy issued by Taxpayer (called a "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy"), provides medical and surgical benefits for employee groups. The policy is a health and accident insurance contract which cannot be cancelled by the company and will remain in force as long as the premium payments are made. The Company reserves the right to make adjustments in the premium rate by class based on experience and on the

policy anniversary date. No premium adjustment can be made by Taxpayer on the basis of any one claim incurred.

14. In establishing the initial premium rate for the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy," Taxpayer establishes a premium rate which will remain level and not be increased for a long period of time. Taxpayer guarantees the initial premium rate for a period of two years; and when the experience requires a premium rate adjustment, Taxpayer guarantees the new rate for at least two years.

15. Taxpayer has developed a formula it uses in determining whether an adjustment in the premium rate will be made. Since instituting the rating formula for the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy," Taxpayer has increased the premium rates of less than 5% of its policyholders.

16. During each of the years involved, Taxpayer established and maintained for the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" reserves for unearned premiums and reserves for unpaid losses. These reserves, plus Taxpayer's life insurance reserves, represented more than 50% of the total reserves maintained by Taxpayer.

17. Taxpayer's books and records were examined by the Texas State Board of Insurance for each of the years involved, and the amount and type of reserves maintained by Taxpayer for all of its policies have been approved. The policies issued by Taxpayer have been filed and approved by the State Board of Insurance.

18. The Texas State Board of Insurance requires that Taxpayer establish and maintain for the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" reserves for unearned premiums and reserves for unpaid losses. The State Board of Insurance does not require any other reserve for health and accident policies where the company has the right to adjust premium rates based on experience and by class although the company does not

have the right to cancel the policy. The State Board of Insurance considers Taxpayer's policy to be a guaranteed renewable health and accident insurance policy.

19. Taxpayer for each of the years involved filed its Federal income tax returns and computed its tax liability on the basis of its being a life insurance company.

20. On examination of Taxpayer's returns by agents of the Internal Revenue Service, the Commissioner of Internal Revenue determined that Taxpayer was not a life insurance company for any of the years involved and, accordingly, assessed and collected deficiency taxes plus interest.

21. Taxpayer timely filed claims for refund which were disallowed. This action was thereafter timely instituted.

## Conclusions of Law

1. Any finding of fact hereinabove made which also constitutes a conclusion of law is adopted as a conclusion of law. Any conclusion of law herein made which also constitutes a finding of fact is hereby adopted as a finding of fact.

[1] 2. According to Treas. Reg. § 1.801-1(a), an insurance company writing only non-cancellable life, health, or accident policies and having no "life insurance reserves" may qualify as a life insurance company if its unearned premiums and unpaid losses on such policies comprise more than 50% of its total reserves.

3. An insurance company is taxed as a life insurance company under Section 801 of the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959, if (1) its life insurance reserves and (2) the reserves for unearned premiums and unpaid losses for guaranteed renewable health and accident contracts constitute more than 50% of its total reserves. The Court finds that the Internal Revenue Code of 1954 requires no other additional reserves in order to qualify as a life insurance company for tax purposes.

4. Plaintiff is an insurance company authorized under Texas law to issue only contracts of life, health and accident insurance.

5. Plaintiff's "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" is a health and accident insurance contract which cannot be cancelled by the company but under which the company has reserved the right to adjust premium rates by class in accordance with the experience under the type of policy involved.

6. The "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" issued by Plaintiff is a guaranteed renewable health and accident insurance contract within the meaning of Section 801(e) of the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959.

7. More than 50% of Plaintiff's total reserves consist of (1) life insurance reserves, and (2) reserves for unearned premiums and unpaid losses on guaranteed renewable health and accident insurance contracts for each year involved.

8. Taxpayer, during each of the years involved, was a life insurance company as defined by Section 801(a) of the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959.

9. Plaintiff is entitled to a refund of the Federal income taxes and interest erroneously assessed and collected by the Defendant, together with interest as provided by law.

APPENDIX B

434 F. 2d 115

IN THE

# United States Court of Appeals

FOR THE FIFTH CIRCUIT

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No. 28992

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GROUP LIFE & HEALTH INSURANCE COMPANY,
*Plaintiff-Appellee,*

v.

UNITED STATES OF AMERICA,
*Defendant-Appellant.*

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(November 5, 1970)

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*Appeal from the United States District Court for the Northern District of Texas*

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Before GEWIN, MORGAN and ADAMS,*
Circuit Judges.

ADAMS, Circuit Judge: This case presents an important and difficult question concerning the Federal taxation of guaranteed renewable health and accident insurance companies under Subchapter L, Part I, § 801 *et seq.* of the Internal Revenue Code of 1954.

* Of the Third Circuit, sitting by designation.

Plaintiff Group Life and Health Insurance Company ("Group Life") underwrites and issues group insurance in Texas under the plan known as Blue Shield. Group Life's parent corporation, Group Hospital Service, Inc., issues insurance in Texas under the plan as Blue Cross. Group Life brought this income tax refund action in the District Court for the Northern District of Texas on the basis that it is entitled to be taxed as a "life insurance company" as defined by § 801(a)[1] of the Internal Revenue Code of 1954 ("the Code"), 26 U.S.C.A. § 801(a). The Honorable Joe E. Estes upheld Group Life's claim and the United States appealed.

The question raised is whether Judge Estes erred in finding that Group Life's "Non-Cancellable, Experience Rated Medical-Surgical Insurance Policy" qualified as "guaranteed renewable life, health, and accident insurance" within § 801(e)[2] of the Code, and whether therefore Group Life qualifies to be taxed as a "life insurance company" within the definition of § 801(a) of the Code. This question depends, in turn, on the validity of § 1.801-3(d) of the Income Tax Regulations ("the Regulations"), 26 C.F.R. § 1.801-3(d): "The term 'guaranteed renewable life, health, and accident policy' means a health and accident contract * * * which is not cancellable by the company but under which the company reserves the right to adjust premium rates by classes in accordance with its experience under the type of policy involved, and *with respect to which a reserve in addition to the unearned premiums * * * must be carried to cover that obligation* * * *" (emphasis added).

To understand the argument that the issuer of Blue Shield group policies may be entitled to be taxed as a life insurance

[1] §801(a) Life Insurance Company Defined — For purposes of this subtitle, the term "life insurance company" means an insurance company which is engaged in the business of issuing life insurance and annuity contracts (either separately or combined with health and accident insurance), or non-cancellable contracts of health and accident insurance, * * *"

[2] § 801(e) provides that guaranteed renewable life, health, and accident insurance shall be treated the same as noncancellable, life, health, and accident insurance.

company requires an examination of the history of income taxation of insurance companies.[3]

Since the enactment of the Revenue Act of 1921,[4] the income of life insurance companies has been taxed differently from that of other corporations. In section 242 of the 1921 Act, Congress decided that a company should be taxed as a life insurance company if it were "engaged in the business of issuing life insurance (including contracts of combined life, health, and accident insurance)", and if the company maintained "for the fulfillment of such contracts" a reserve which comprised "more than 50 per centum of its total reserve funds." Such companies were allowed, among other benefits, to exclude premium income from their computation of taxable income because such receipts "were not true income but were analogous to permanent capital investment." *Helvering v. Oregon Mutual Life Insurance Company*, 311 U.S. 267,269, 61 S. Ct. 207, 208, 85 L. Ed. 180 (1940). This concept was based on the premise that premiums received in the early years of a level-payment life insurance policy must be invested in order to satisfy risks which increase with the age of the insured. Payments received in the early years exceed the risks of the early years, and such premiums thereby augment premiums for later years which would otherwise be insufficient to insure the risks which develop in later years. Significantly this characterization of a life insurance company for Federal income tax purposes, set forth in the 1921 Act, made the policy reserves of a company the touchstone of the catagory in which it was to be placed. *Alinco Life Insurance Co., supra,* at 347; *see also Commissioner v. Swift & Co., E.B.A.*, 151 F. 2d 625 (7th Cir. 1945).

Defining insurance companies in terms of their reserves for tax purposes next led Congress to recognize that "non-

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[3] For a comprehensive review of the history of the income taxation of life insurance companies, see Alinco Life Insurance Co. v. United States, 373 F. 2d 336, 345-349 (Ct. Cl. 1967); Vickrey, Insurance Under the Federal Income Tax, 52 YALE L. J. 554 (1943); Mertens, Law of Federal Income Taxation, §4401 (Zimit ed. 1964).

[4] Law of November 23, 1921, ch. 136, 42 Stat. 227.

cancellable" health and accident policies ought to be treated similarly to life policies. This is so because an insurance company in issuing non-cancellable health and accident policies makes provision in the early years for the increased actuarial risks in later years, and has a reserve to reflect this fact. The Revenue Act of 1942,[5] therefore, expanded the class of corporations taxable as life insurance companies to include those issuing noncancellable health and accident policies. The Senate Finance Committee explained the rationale for such treatment as follows:

> "Since noncancellable contracts of health and accident insurance require the accumulation of substantial reserves against increased future risks, the writing of such insurance is analogous to life insurance * * * The life insurance reserves defined in * * * [§ 201] (c) (2) [superceded by § 801 (b) of the present code] as they pertain to noncancellable health and accident insurance policies are those amounts which must be reserved, in addition to unearned premiums, to provide for the additional cost of carrying such policies in later years when the insured will be older and subject to greater risk and when the cost of carrying the risk will be greater than the premiums then being received." S.Rep. No. 1631, 77th Cong., 2d Sess. (1942-2 Cum. Bull. 504, 611-612).

To accommodate the mechanics of health and accident insurance, the casualty insurance terms of "unearned premiums" and "unpaid losses" were added to the definition of a life insurance company in essentially the same language as that of the present § 801(a) of the Code. Unearned premiums are "those amounts which shall cover the cost of carrying the insurance risk for the period for which the premiums have been paid in advance." § 1.801-3(e) of the Regulations. The reserve for unpaid losses "represents the present value of all benefits not yet accrued at the date of valuation, arising from disabilities already incurred

[5] Law of October 21, 1942, ch. 619, 56 Stat. 798.

* * *".[6] *Commissioner v. Monarch Life Insurance Company*, 114 F. 2d 314, 322 (1st Cir. 1940). Thus, neither of these reserves cover the increased actuarial risks which accrue over the term of noncancellable policies, and an additional reserve must be maintained — a reserve similar to that maintained for level-payment straight-life insurance where "the factor for future premium difficiencies is an integral part of the actuarial tables on the basis of which the mortality reserve is computed." *Alinco Life Insurance Company, supra*, at 355, fn 37. See also *Massachusetts Protective Association v. United States*, 114 F. 2d 304, 309 (1st Cir. 1940); § 1.801-3(c) of the Regulations.

As a result of a comprehensive review of the taxation of life insurance companies, Congress enacted the Life Insurance Company Income Tax Act of 1959.[7]

This Act added § 801(e) to the Code:

> "For purposes of this part, guaranteed renewable life, health, and accident insurance shall be treated in the same manner as noncancellable life, health, and accident insurance."

The Senate Finance Committee explained that this provision was to cover "life, health, and accident policies which are not cancellable by the company but under which the insurance company reserves the right to adjust premium rates by classes, in accordance with experience under the type of policy involved." S. Rep. No. 291, 86th Cong., 1st Sess. (1959-2 Cum Bull. 770, 793).

Group's Life Blue Shield plan provides medical and surgical benefits for employee groups. The contracts of insurance are between Group Life and various employers, with each employee member receiving a certificate indicating coverage. The policy may not be cancelled by Group Life, but the premium rate may be adjusted periodically, based on experience by class. This rate adjustment feature is a characteristic of a "guaranteed renewable" policy rather than

[6] For a more precise definition, see § 1.801-3(g) of the Regulations.

[7] 26 U.S.C.A. §§ 801-820.

a "noncancellable policy (despite the Group Life's name for the policy). The initial premium charged by Group Life was found by the District Court to remain level for two years, and the adjusted premium thereafter is to be guaranteed for at least two years.[8]

The Texas State Board of Insurance requires that Group Life maintain reserves for unearned premiums and for unpaid losses for its guaranteed renewable contracts. No other reserves are required by the Board where a company has the right to adjust premium rates based on experience and by class. Consequently, the Board considers Group Life's policy to be a "guaranteed renewable health and accident policy" for purposes of Texas law. While Congress has occasionally enacted Federal tax provisions which depend on underlying state definitions and thus result in varying treatment between taxpayers of the several states,[9] the life insurance company provisions of the Code evidence an intent that insurance companies are taxed uniformly. We consequently are required to determine what Congress meant by the term "guaranteed renewable" contracts.

As set forth above, the history of special taxation of life, health, and accident insurance companies arose from their need to set aside as reserves a substantial portion of premium and investment income in the early years of a policy to cover the cost of the policy in later years when the actuarial cost will be greater. *See United Benefit Life Insurance Co. v. McCrory*, 414 F. 2d 928, 929-930 (8th Cir. 1969). This need to fund long-term actuarial risks was

[8] The specimen policy supplied by Group Life as Stipulation Exhibit B, however, provides in Article IV. B. that "the Insurer reserves the right to change the schedule of premium rates on any policy anniversary, as applicable to the succeeding year." "Policy anniversary" is defined in turn by Article I.J. to mean "the month and day of any subsequent year corresponding to the policy date." The discrepancy between these provisions and the finding by the District Court remains unexplained.

[9] An example is the definition of legal relationships between husband and wife, especially with respect to community property versus common law treatment. *See e.g.*, Westfall, *Revitalizing the Federal Estate and Gift Taxes*, *83* HARV. L. REV. 986, 998-1000 (1970).

explicitly recognized as justifying the inclusion of non-cancellable contracts. In providing that guaranteed renewable contracts should be treated in the same manner as noncancellable contracts, the Senate Finance Committee stated:

> "Reserves with respect to such insurance will, therefore, be treated in the same manner as life insurance reserves for purposes of computing taxable investment income and gains from operations." S. Rep. No. 291, 86th Cong., 1st Sess. (1959-2 Cum. Bull. 770, 793).

In light of the prior history of this area of taxation and the fact that life insurance reserves are not treated in the same manner as unearned premium and unpaid loss reserves for income tax *computational purposes*,[10] it seems clear that Congress understood the reserves mentioned in the Senate Finance Committee Report to be in addition to unearned premium or unpaid loss reserves. The purpose of the reserves referred to in the Report is to cover the increasing cost of the insurance as the insured (individual or group) grows older. In contrast, the purpose of the periodic adjustment of premiums based on experience allowed under a guaranteed renewable policy is not to respond to an increase in the actuarial risks (which Group Life's REX formula[11]

[10] See *e.g.*, §805(c) of the Code; Rev. Rul. 70-460, 1970 Int. Rev. Bull. No. 36 at 8. *See generally* United States v. Atlas Life Insurance Co., 381 U.S. 233, 85 S. Ct. 1379, 14 L. Ed. 358 (1965); Western National Life Insurance Co. of Texas v. Commissioner, 5 Cir., 1970 ..... F. 2d ..... [No. 28560, Sept. 30, 1970)].

[11] The REX formula is the revised rating formula used by Group Life to adjust the premiums on the basis of experience. The following description of its mechanics is taken from the Stipulation of the parties filed in the District Court:

> "The Rex formula is a formula whereby the experience of each group (referred to as 'group experience') is combined with the experience of all groups subject to this formula (referred to as 'community experience'). The community experience is the combined experience of all groups rated under the Rex Formula for the past twelve months, and for the years involved herein was 83%. The relative weight of each group's experience to the community experience is based on the individual group's combined income for the preceding three years (referred to as 'credibility factor'). The Rex Formula is applied as follows: A. Each group's cumulative three year premium income is

determined and that amount is then used to determine the relative weight to be given to the group's experience by application of the following credibility table:

*CREDIBILITY TABLE*

| *Cumulative Income for Last Three Years* | *Experience Group* | *Recognition Community* |
|---|---|---|
| 0 — 3,999 | 20% | 80% |
| 4,000 — 5,999 | 30% | 70% |
| 6,000 — 8,999 | 40% | 60% |
| 9,000 — 12,999 | 50% | 50% |
| 13,000 — 17,999 | 60% | 40% |
| 18,000 — 23,999 | 70% | 30% |
| 24,000 — 30,000 | 80% | 20% |
| 31,000 — up | 90% | 10% |

For example, a group with a total three year premium of $7,000.00 would use 40% of its group experience and 60% of the community experience in determining the increase or decrease in the premium rate.

B. The next step is to determine the experience factor for each group. This is computed by dividing the total claims paid by the total premium income for the past three years.

For example, a group having premium income of $7,000.00 and claims of $6,500.00 over a three years period has a group experience of 93%, ($6,500.00 ÷ $7,000.00).

C. The next step is to combine the group's own experience factor with the community experience factor in accordance with the credibility table as follows:

(1) Multiply the group's credibility factor times the group's experience factor. For example, a group having 40% credibility factor and a 93% experience factor has a resulting factor of 37.2%, (40% x 93%).

(2) Multiply the community's credibility factor times the community's experience factor. A community credibility factor of 60 times the community experience of 83% gives a resulting factor of 49.8% (60% x 83%).

(3) The group factor, 37.2%, is added to the community factor, 49.8%, and the result, 87.0%, is the adjusted three year ratio.

would do) but to cover such factors as in
medical care or an increase in the injury rat
or trade. The Supreme Court has declared
regulations must be sustained unless u
plainly inconsistent with the revenue statu
*missioner v. South Texas Co.*, 333 U.S. 49
695, 92 L. Ed. 831 (1948). Treasury Regulat
is neither "unreasonable" nor "plainly in
§ 801(e) of the Code, and must therefore

The question remains whether Grou
in fact developed the additional reserv
§ 1.801-3(d) of the Regulations. Although
lated in the District Court this question to
puted issue of fact, that Court made no find
Fed. R. Civ. P. 52(a) regarding it.[12] Becau
concluded as a matter of law that no additi
needed by Group Life to qualify as a life
pany, he did not have to resolve the foreg
fact. Such conclusion of law, however, ca
decision upholding the validity of the above

creased costs of
e of a profession
"that Treasury
nreasonable and
es * * *". *Com-*
6, 501, 68 S. Ct.
ions § 1.801-3(d)
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be the sole dis-
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onal reserves are
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nnot survive the
Regulation. The

D. Reference is then made to the Rate Ad
determine whether the premium rate for the ne
remain the same, will be increased, or will be d
adjustment table is as follows:

justment Table to
xt policy year will
ecreased. The rate

RATE ADJUSTMENT TABLE

| *Adjusted Ratio* | *Rate Adjustment* |
|---|---|
| Up to 59.9% | — 15% |
| 60% to 69.9% | — 10% |
| 70% to 82.9% | 0% |
| 83% to 90.9% | + 8% |
| 91% to 94.9% | + 12% |
| 95% to 98.9% | + 16% |
| 99% and up | + 20% |

For example, a group with a total adjusted th
will have an increase in premiums of 8% over

ee year ratio of 87%
the previous year.

[12] Group Life, unlike the United States, d
Estes to resolve this question in its "Proposed
Conclusions of Law" filed in the District C
quested only a finding that "An additional
reserve based on recognized morbidity tables c
Taxpayers' [policy]" (emphasis added). Th
not adopt this proposed finding.

d not request Judge
Findings of Fact and
urt. Group Life re-
ctuarially computed
*uld be* established for
District Court did

District Court's finding that Group Life "establishes a premium rate which will remain level and not be increased for a long period of time" does not dispose of the question of an additional reserve because the earned premium income which is not a part of Group Life's reserve for unpaid claims may be used for *any* purpose.

Group Life has not established the existence of the requisite reserve — a burden this taxpayer must carry to recover taxes alleged to have been erroneously collected. *E.g. United States v. Anderson*, 269 U.S. 422, 46 S. Ct. 131, 70 L. Ed. 347 (1926). No such reserve was reported in Group Life's annual financial statements, and Group Life's witnesses neither established the existence of nor the need for such reserve with respect to the policy here in question. Indeed, the Government's actuary testified this type of policy would not require an additional reserve, and one of Group Life's witnesses testified that only unearned premium and unpaid loss reserves were in fact maintained. Group Life's statistician did not testify to the contrary, as suggested by Group Life in its brief, but rather discussed only the computation of the initial premium, not the use to which the funds were put. We do not agree with Group Life's argument that the Commissioner of Internal Revenue may not require a group life, health, and accident insurance company to maintain the extra reserve specified by § 1.801-3(d) of the Regulations in order to qualify as a "life insurance company for Federal tax purposes" because the company is not required by the State of Texas to maintain such a reserve. Section 801(b) (2) of the Code does not limit the definitional power of the Commissioner, but on the contrary limits the reserves a company may claim as "life insurance reserves" for Federal income tax purposes. *See generally Drummand Citizens Insurance Company v. United States*, 298 F. Supp. 692 (E. D. Ark. 1969). We express no opinion concerning the wisdom of denying to Group Life the benefits of life insurance company classification for income tax purposes. We must, however, conclude such treatment is foreclosed under existing law.

Accordingly, the judgment of the District Court is reversed.

# United States Court of Appeals
## FOR THE FIFTH CIRCUIT

**OCTOBER TERM, 1970**

**No. 28992**

**D. C. Docket No. CA 3-2095**

GROUP LIFE & HEALTH INSURANCE COMPANY,
*Plaintiff-Appellee,*

*v.*

UNITED STATES OF AMERICA,
*Defendant-Appellant.*

*Appeal from the United States District Court for the* Northern District of Texas

Before GEWIN, MORGAN and ADAMS,*
Circuit Judges.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Northern District of Texas, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed.

It is further ordered that plaintiff-appellee pay to defendant-appellant, the costs on appeal to be taxed by the Clerk of this Court.

**APPENDIX C**

**IN THE**

# United States Court of Appeals
**FOR THE FIFTH CIRCUIT**

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**No. 28992**

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GROUP LIFE & HEALTH INSURANCE COMPANY,
*Plaintiff-Appellee,*

v.

UNITED STATES OF AMERICA,
*Defendant-Appellant.*

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*Appeal from the United States District Court for the Northern District of Texas*

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*ON PETITION FOR REHEARING AND PETITION FOR REHEARING EN BANC*
(Opinion Nov. 5, 1970, 5 Cir., 1970, ..... F. 2d .....).

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(January 8, 1971)

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Before GEWIN, MORGAN and ADAMS,*
Circuit Judges.

PER CURIAM: The Petition for Rehearing is DENIED and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc, (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the Petition for Rehearing En Banc is DENIED.

* Of the Third Circuit, sitting by designation.

# APPENDIX D

Rule 52(a), Federal Rules of Civil Procedure:

## Rule 52.

## FINDINGS BY THE COURT

(a) Effect. In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon, and judgment shall be entered pursuant to Rule 58; and in granting or refusing interlocutory injunctions the court shall similarly set forth the findings of fact and conclusions of law which constitute the grounds of its action. Requests for findings are not necessary for purposes of review. Findings of fact shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses. The findings of a master, to the extent that the court adopts them, shall be considered as the findings of the court. If an opinion or memorandum of decision is filed, it will be sufficient if the findings of fact and conclusions of law appear therein. Findings of fact and conclusions of law are unnecessary on decisions of motions under Rules 12 or 56 or any other motion except as provided in Rule 41(b).

(28 U.S.C. 14)

# APPENDIX E

Internal Revenue Code of 1954: (as amended by the Life Insurance Company Income Tax Act of 1959).

SEC. 801 DEFINITION OF LIFE INSURANCE COMPANY.

(a) *Life Insurance Company Defined.* — For purposes of this subtitle, the term "life insurance company" means an insurance company which is engaged in the business of issuing life insurance and annuity contracts (either separately or combined with health and accident insurance), or noncancellable contracts of health and accident insurance, if —

(1) its life insurance reserves (as defined in subsection (b)), plus

(2) unearned premiums and unpaid losses (whether or not ascertained), on noncancellable life, health, or accident policies not included in life insurance reserves,

comprise more than 50 percent of its total reserves (as defined in subsection (c)).

(b) *Life Insurance Reserves Defined.* —

(1) *In general.* — For purposes of this part, the term "life insurance reserves" means amounts —

(A) which are computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest, and

(B) which are set aside to mature or liquidate, either by payment or reinsurance, future unaccrued claims arising from life insurance, annuity, and noncancellable health and accident insurance contracts (including life insurance or annuity contracts combined with noncancellable health and accident insurance) involving, at the time with respect to which the reserve is computed, life, health, or accident contingencies.

(2) *Reserves must be required by law.* — Except —

(A) in the case of policies covering life, health, and accident insurance combined in one policy issued on the weekly premium payment plan, continuing for life and not subject to cancellation,

(B) in the case of policies issued by an organization which meets the requirements of section 501(c)(9) other than the requirement of subparagraph (B) thereof, and

(C) as provided in paragraph (3),

in addition to the requirements set forth in paragraph (1), life insurance reserves must be required by law.

* * * * *

(c) *Total Reserves Defined.* — For purposes of subsection (a), the term "total reserves" means —

(1) life insurance reserves,

(2) unearned premiums, and unpaid losses (whether or not ascertained), not included in life insurance reserves, and

(3) all other insurance reserves required by law.

The term "total reserves" does not include deficiency reserves (within the meaning of subsection (b)(4)).

* * * * *

(e) *Guaranteed Renewable Contracts.* — For purposes of this part, guaranteed renewable life, health, and accident insurance shall be treated in the same manner as noncancellable life, health, and accident insurance.

* * * * *

(26 U.S.C. 1964 ed., Sec. 801)

# APPENDIX F

Treasury Regulations on Income Tax (1954 Code); (filed December 9, 1960):

SEC. 1.801-1 *Definitions.*

(a) *Life insurance company.* The term "life insurance company" as used in subtitle A of the code is defined in section 801. For the purpose of determining whether a company is a "life insurance company" within the meaning of that term as used in section 801, it must first be determined whether the company is taxable as an insurance company under the Code. For the definition of an "insurance company" see paragraph (b) of this section. In determining whether an insurance company is a life insurance company, the life insurance reserves (as defined in section 803(b)) plus any unearned premiums and unpaid losses on noncancellable life, health, or accident policies, not included in "life insurance reserves" must comprise more than 50 percent of its total reserves (as defined in section 801). An insurance company writing only noncancellable life, health, or accident policies and having no "life insurance reserves" may qualify as a life insurance company if its unearned premiums and unpaid losses on such policies comprise more than 50 percent of its total reserves. A noncancellable insurance policy means a contract which the insurance company is under an obligation to renew or continue at a specified premium and with respect to which a reserve in addition to the unearned premium must be carried to cover that obligation. For the purpose of the preceding sentence, the term "unearned premium" means the amount which will cover the cost of carrying the insurance risk for the period for which the premium has been paid in advance. A burial or funeral benefit insurance company qualifying as a life insurance company engaged directly in the manufacture of funeral supplies or the performance of funeral services will be taxable under section 821 or section 831 as an insurance company other than life.

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(26 C.F.R., Sec. 1.801-1.)

SEC. 1.801-3 *Definitions.*

* * * * *

(b) *Life insurance company.* (1) The term "life insurance company" as used in subtitle A of the Code, is defined in section 801(a). For the purpose of determining whether a company is a "life insurance company" within the meaning of that term as used in section 801(a), it must first be determined whether the company is taxable as an insurance company (as defined in paragraph (a) of this section). An insurance company shall be taxed as a life insurance company if it is engaged in the business of issuing life insurance and annuity contracts (either separately or combined with health and accident insurance), or noncancellable contracts of health and accident insurance, and its life insurance reserves (as defined in section 801(b) and sec. 1.801-4), plus unearned premiums and unpaid losses (whether or not ascertained), or noncancellable life, health, or accident policies not included in life insurance reserves, comprise more than 50 percent of its total reserves (as defined in section 801 (c) and sec. 1.801-5). For purposes of determining whether it satisfies the percentage requirements of the preceding sentence, a company shall first make any adjustments to life insurance reserves and total reserves required by section 806(a) (relating to adjustments for certain changes in reserves and assets) and then as required by section 801(d) (relating to adjustments in reserves for policy loans). For examples of the adjustments required under section 806(a), see paragraph (b) (4) of sec. 1.806-3. For an example of the adjustments required under section 801(d), see paragraph (c) of sec. 1.801-6. Furthermore, if an insurance company which computes its life insurance reserves on a preliminary term basis elects to revalue such reserves on a net level premium basis under section 818(c), such revalued basis shall be disregarded for purposes of section 801.

(2) An insurance company writing only noncancellable life, health, or accident policies and having no "life insur-

ance reserves" may qualify as a life insurance company if its unearned premiums, and unpaid losses (whether or not ascertained), on such policies comprise more than 50 percent of its total reserves.

* * * * *

(c) *Noncancellable life, health, or accident insurance policy.* The term "noncancellable life, health, or accident insurance policy" means a health and accident contract, or a health and accident contract combined with a life insurance or annuity contract, which the insurance company is under an obligation to renew or continue at a specified premium and with respect to which a reserve in addition to the unearned premiums (as defined in paragraph (e) of this section) must be carried to cover that obligation. Such a health and accident contract shall be considered noncancellable even though it states a termination date at a stipulated age, if, with respect to the health and accident contract, such age termination date is 60 or over. Such a contract, however, shall not be considered to be noncancellable after the age termination date stipulated in the contract has passed. However, if the age termination date stipulated in the contract occurs during the period covered by a premium received by the life insurance company prior to such date, and the company cannot cancel or modify the contract during such period, the age termination date shall be deemed to occur at the expiration of the period for which the premium has been received.

(d) *Guaranteed renewable life, health, and accident insurance policy.* The term "guaranteed renewable life health, and accident insurance policy" means a health and accident contract, or a health and accident contract combined with a life insurance or annuity contract, which is not cancellable by the company but under which the company reserves the right to adjust premium rates by classes in accordance with its experience under the type of policy involved, and with respect to which a reserve in addition to the unearned premiums (as defined in paragraph (e) of this section) must be carried to cover that obligation. Section 801(e) provides

that such policies shall be treated in the same manner as noncancellable life, health, and accident insurance policies. For example, the age termination date requirements applicable to noncancellable health and accident insurance policies shall also apply to guaranteed renewable life, health, and accident insurance policies. See paragraph (c) of this section.

(e) *Unearned premiums.* The term "unearned premiums" means those amounts which shall cover the cost of carrying the insurance risk for the period for which the premiums have been paid in advance. Such term includes all unearned premiums, whether or not required by law.

* * * * *

(g) *Unpaid losses (whether or not ascertained).* The term "unpaid losses (whether or not ascertained)" means a reasonable estimate of the amount of the losses (based upon the facts in each case and the company's experience with similar cases) —

(1) Reported and ascertained by the end of the taxable year but where the amount of the loss has not been paid by the end of the taxable year,

(2) Reported by the end of the taxable year but where the amount thereof has not been either ascertained or paid by the end of the taxable year, or

(3) Which have occurred by the end of the taxable year but which have not been reported or paid by the end of the taxable year.

* * * * *

(26 C.F.R., Sec. 1.801-3.)

SEC. 1.801-4 *Life insurance reserves.*

* * * * *

(e) *Reserves and liabilities which do not qualify as life insurance reserves.* The following are illustrative of reserves

and liabilities which do not meet the requirements of section 801(b) and paragraph (a) of this section and, accordingly, shall not be included as life insurance reserves:

* * * * *

(3) The unearned premiums, and unpaid losses (whether or not ascertained), on noncancellable life, health, or accident policies (and guaranteed renewable life, health, and accident policies) not included in life insurance reserves. (However, such amounts shall be taken into account under section 801(a)(2) for purposes of determining whether an insurance company is a life insurance company.)

* * * * *

(26 C.F.R., Sec. 1.801-4.)

# In the Supreme Court of the United States

OCTOBER TERM, 1970

No. 1378

GROUP LIFE & HEALTH INSURANCE COMPANY,
PETITIONER

*v.*

UNITED STATES OF AMERICA

*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT*

## BRIEF FOR THE UNITED STATES IN OPPOSITION

### OPINIONS BELOW

The opinion of the district court (Pet. App. A1–A6) is not reported. The opinion of the court of appeals (Pet. App. B1–B10) is reported at 434 F. 2d 115.

### JURISDICTION

The judgment of the court of appeals was entered on November 5, 1970 (Pet. 2; Pet. App. B11). A petition for rehearing and for rehearing *en banc* was denied on January 8, 1971 (Pet. App. C1). The petition for a writ of certiorari was filed on February 22,



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1971. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## QUESTIONS PRESENTED

1. Whether the court of appeals correctly sustained Treasury Regulations 1.801–3(d), defining a guaranteed renewable life, health and accident insurance policy as a policy "with respect to which a reserve in addition to the unearned premiums * * * must be carried * * *."

2. Whether the evidence introduced by petitioner at trial was insufficient as a matter of law to support its contention that, in any event, it did carry the requisite reserve, so that it was unnecessary for the court of appeals to remand for a new trial.

## STATUTE AND REGULATIONS INVOLVED

The pertinent statutory and regulatory provisions are set forth in appendices D, E and F to the petition.

## STATEMENT

Late in 1960, petitioner, a Texas insurance company, began to issue medical and surgical insurance as part of the Blue Shield plan in Texas. In 1961, 1962 and 1963, all of its medical and surgical policies were for group coverage under a contract called the "Non-cancellable, Experience Rated Medical-Surgical Insurance Policy" (hereinafter, the "group policy").[1]

[1] The group policy (Stip. Ex. B) provided medical and surgical benefits for employee groups. The master contract was between petitioner and the employer, with each member of the employee group receiving a certificate of coverage under the master contract. Although petitioner had the right to adjust

In 1964, petitioner also issued some individual policies for medical-surgical coverage, and in each of the years involved (1961 through 1964) it issued a small amount of life insurance (Pet. App. A1–A3).

Petitioner claimed entitlement to income tax treatment for the years in suit as a life insurance company as defined in Section 801 of the Internal Revenue Code of 1954. That section provides that an insurance company will qualify as a life insurance company for income tax purposes if its life insurance reserves plus unearned premiums and unpaid losses for guaranteed renewable health and accident insurance contracts comprise more than 50 percent of its total reserves. Section 801 (a) and (e). Since it was agreed that the reserves for unearned premiums and unpaid losses maintained by petitioner for its group policies, together with its life insurance reserves, would constitute more than 50 percent of its total reserves (Pet. App. A4), petitioner's qualification as a life insurance company depended on a showing that its group policies were guaranteed renewable health and accident policies within the meaning of Section 801(e) of the Code (Pet. App. B2).

Treasury Regulations 1.801–3(d) (Pet. App. F3–F4) defines guaranteed renewable health and acci-

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premiums by class in accordance with its experience, the group policy could not be cancelled by it and remained in force so long as the premiums were paid (Pet. App. A3–A4). However, the policy terminated by its own terms if a certain minimum level of employee participation was not maintained (Stip. Ex. B, Art. VIII A3(c)), and individual coverage terminated if the individual ceased to be an employee (Stip. Ex. B, Art. VIII A1).

dent policies as policies which are not cancellable by the company (although the company reserves the right to adjust premiums by classes in accordance with its experience) "and with respect to which a reserve in addition to the unearned premiums * * * must be carried * * *." Petitioner argued in the district court that the additional reserve requirement was invalid and that its group policy need not develop the additional reserve required by Treasury Regulations 1.801–3(d) in order to qualify as a guaranteed renewable health and accident contract. It also argued for a finding that in any event "[a]n additional actuarially computed reserve based on recognized morbidity tables could be established" for its group policy (Pet. App. B9 n. 12). The district court, without specifically addressing itself to the Regulations, held that no additional reserve was required in addition to unearned premiums and that petitioner's group policies therefore qualified as guaranteed renewable policies under Section 801(e).

The court of appeals reversed and upheld the regulatory requirement for an additional reserve (Pet. App. B1–B10). Finding the record devoid of evidence which would support a contention that the additional reserve requirement had been met, the court concluded that a remand on this latter point was unwarranted (Pet. App. B10).

## ARGUMENT

The decision below is correct. There is no conflict of decisions or any other reason for further review.

1. The opinion of the court of appeals fully answers petitioner's challenge (Pet. 18) to the validity of Treasury Regulations 1.801–3(d). As the opinion makes clear (Pet. App. B2–B9), the special tax treatment afforded life insurance companies is based on legislative recognition of the unique character of the reserves which must be maintained on life insurance. Unlike casualty insurance companies (taxable under Sections 831 and 832), the reserves of which are generally limited to unearned premiums and unpaid losses, life insurance companies must maintain reserves for the funding of long-term actuarial risks. Because a level premium (based upon the insured's insurance age) is employed, amounts must be set aside as reserves in the early policy years to fund the actuarial risk which will increase with the age of the insured and which will cause insurance costs to exceed the level premium in later years. It is these reserves, required by the long-term actuarial risk, which underlie the special tax treatment fashioned for life insurance companies. See *Alinco Life Insurance Company* v. *United States,* 373 F. 2d 336, 345–349; *Massachusetts Protective Assn.* v. *United States,* 114 F. 2d 304 (C.A. 1); Mertens, *Law of Federal Income Taxation,* § 44.01 (Vol. 8).

In 1942, Congress broadened the statutory life insurance company classification to allow companies issuing noncancellable health and accident policies to qualify for life insurance company tax status. In 1959, Congress included companies issuing guaranteed renewable policies, stating that such policies would be

treated in the same manner as noncancellable policies. In amending the statute, Congress did not abandon the long-term reserve test. On the contrary, as the legislative history of Section 801 and its predecessor provisions bears out, the only reason for including noncancellable and guaranteed renewable health and accident policies was their resemblance to life insurance in that they also require a reserve over and above unearned premiums to cover the increasing actuarial risks. See S. Rep. No. 1631, 77th Cong., 2d Sess., pp. 144–145. S. Rep. No. 279, 86th Cong., 1st Sess., p. 32.[2] Where there is no need for such a reserve, there is no basis for tax treatment as a life insurance company. The requirement in the Regulations that a policy have such additional reserve in order to fall within the "guaranteed renewable" category correctly reflects the legislative intendment and is consistent with the statute.[3] Therefore, the Regulations were properly sustained. See *Commissioner* v. *South Texas Co.*, 333 U.S. 496, 501; *Bingler* v. *Johnson*, 394 U.S. 741, 749–751.

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[2] The opinion of the court of appeals (Pet. App. B4–B7) contains an accurate and full discussion of this legislative history. Petitioner is simply in error in suggesting (Pet. 18) that the Committee Reports do not support the Regulations.

[3] Petitioner's assertion of conflict (Pet. 16–18) with *Helvering* v. *Oregon Mutual Life Ins. Co.*, 311 U.S. 267, is without merit. That case involved a different statute and an entirely different and unrelated question—whether a corporation admittedly taxable as a life insurance company was entitled to a deduction for certain legally required disability reserves under Section 203(a)(2) of the Revenue Acts of 1932 and 1934 (47 Stat. 224, 48 Stat. 732).

2. Petitioner contends that the court of appeals erred in not remanding the case to the district court for a factual finding on whether its group policy in fact developed the reserve required by Regulations 1.801–3(d). It relies (Pet. 8–15) on the many cases holding that when a trial court has failed to make an essential finding of fact on which there is a conflict in the evidence, the case should be remanded to the trial court for a further factual finding.[4] But, it is equally true that a remand is not inevitably required simply because a finding is not made below. There must be a genuine dispute with respect to the undecided factual issue, and the record must be such as would support a factual determination either way by the trial court. Where the record does not present a genuine issue of fact, a remand is unnecessary. See *Yanish* v. *Barber,* 232 F. 2d 939, 947 (C.A. 9), and authorities cited therein; *W. M. Webb, Incorporated* v. *United States,* 424 F. 2d 1070 (C.A. 5), certiorari denied, 400 U.S. 902; Barron and Holtzoff, 2B, *Federal Practice and Procedure,* § 1138; *Cyclopedia of Federal Practice* (3d ed.), Vol. 14, § 68.99.

Here, petitioner's proof in the district court fell short, as a matter of law, of supporting a finding that the requisite reserve had in fact been developed.[5] As

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[4] The Fifth Circuit, like every other circuit, follows this rule. See *S. S. Silberblatt* v. *United States,* 353 F. 2d 545; *Mladinich* v. *United States,* 371 F. 2d 940.

[5] Significantly, at the close of the evidence in the district court, petitioner did not even ask for a finding that the additional reserve had been developed. It requested only a finding that a reserve *could be* established, but that requested finding was not made (Pet. App. B9 n. 12).

the court of appeals perceived (Pet. App. B7–B9), the very nature of the premium adjustment formula on the group policy precluded the generation of an additional reserve. Premium adjustments took into account increasing actuarial risks, thus obviating the need for an additional reserve to fund those risks. Petitioner's suggestion that nevertheless the requisite reserve was carried is refuted on the record and is unsupported by proof. As the court of appeals pointed out (Pet. App. B10):

> No such reserve was reported in Group Life's annual financial statements, and Group Life's witnesses neither established the existence of nor the need for such reserve with respect to the policy here in question. Indeed, the Government's actuary testified this type of policy would not require an additional reserve, and one of Group Life's witnesses testified that only unearned premium and unpaid loss reserves were in fact maintained. Group Life's statistician did not testify to the contrary, as suggested by Group Life in its brief, but rather discussed only the computation of the initial premium, not the use to which the funds were put. * * *

The court's evaluation of the record is correct[6] and

[6] Petitioner's own assistant controller testified that only unearned premiums and unpaid loss reserves were maintained (R. 163–164). And, in each of petitioner's annual statements filed with the State Board of Insurance of Texas (Stip. Exs. H, I, J, K), no amount appears in Exhibit 9 (p. 11 of the statement) as Item 2 under Part 1 entitled "Additional reserves for guaranteed renewable policies." Moreover, the evi-

clearly within the province of an appellate court. At all events, petitioner's disagreement with the Fifth Circuit's evaluation of the record does not warrant review by this Court.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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dence relied on by petitioner to show a "disputed" issue of fact (Pet. 6–7), was explicitly adverted to and rejected by the court (Pet. App. B10).

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